THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

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The public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0323). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for falling to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1095 and 1079b; Executive Order 9397.

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, the information on this form will be released to your insurance company.

| 4 PA 4 PRINTS IN \$ 1 A B 4 PA | PATIEN | T INFORMATION | | | | | | |
|---|--|---|---|---|--|--|--|--|
| 1. PATIENT NAME (Last, First, Mid | die initial) | 2. SSN | | 3. DATE OF BIRTH (YYYY/MM/DD | | | | |
| 4a. MAILING ADDRESS (Include 2 | ZIP Code) | | IOME TELEPHO) FAMILY MEMB | NE NO. | | | | |
| | | | PREFIX | * | | | | |
| 6a. PATIENT'S EMPLOYER'S NA | AME | b. I | b. EMPLOYER TELEPHONE NUMBER () | | | | | |
| | INSURAN | CE INFORMATION | | | | | | |
| DO YOU HAVE OTHER HEAL coverage, and Medicare Suppl | .TH INSURANCE? (This includes en lement.) | mployer health insurance | benefits, other c | ommercial health insurance | | | | |
| a. YES. (Complete Item 8 a | nd the remaining sections below.) | M | | | | | | |
| b. NO, I am a DoD beneficia | ry and rely solely on TRICARE, Med | licare, or Medicaid. (Proc | eed to Item 12.) | | | | | |
| c. NO, but I am not a DoD b | eneficiary. (Proceed to Item 11.) | | | | | | | |
| PRIMARY MEDICAL INSURA please provide it and proceed it | NCE INFORMATION. If you have an to item 10; otherwise, please comple | n insurance card that can te the blocks below. | be copied or sca | anned by the MTF representative, | | | | |
| a. NAME OF POLICY HOLDER (| Last, First, Middle Initial) | b. DATE OF BIRT | o. DATE OF BIRTH (YYYY/MM/DD) c. RELATIONSHIP TO POLI HOLDER | | | | | |
| J. POLICY HOLDER'S EMPLOYE | R'S NAME, ADDRESS AND TELEP | HONE NUMBER | | | | | | |
| | • | | • | | | | | |
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| | | | | | | | | |
| INSURANCE COMPANY NAMI | E ADDRESS AND TELEPHONE N | IMBER | | | | | | |
| 9. INSURANCE COMPANY NAMI | E, ADDRESS AND TELEPHONE NU | JMBER | | | | | | |
| B. INSURANCE COMPANY NAMI | E, ADDRESS AND TELEPHONE NU | JMBER | | | | | | |
| e. INSURANCE COMPANY NAMI | E, ADDRESS AND TELEPHONE NU | JMBER h. GROUP POLICY | , (ID | ì. GROUP PLAN NAME | | | | |
| f. CARD HOLDER ID | | | | i. GROUP PLAN NAME m. POLICY END DATE (YYYY/MM/DD) | | | | |
| f. CARD HOLDER ID i. ENROLLMENT/PLAN CODE | g. POLICYID | h. GROUP POLICY I. POLICY EFFEC (YYYY/MM/DD) | TIVE DATE | m. POLICY END DATE | | | | |

| SECONDARY MEDICAL INSU please provide it and proceed to | RANCE INFOR tem 10; othe | RMATION: erwise, plea | If you have an se complete the | insu: | rance card that can books below. | e copled or | scanned by th | ne MTF | repre | sentative, | | |
|--|---|--|--|--|--|--|--|--|--|---|--|--|
| a. NAME OF POLICY HOLDER (Last, First, Middle Initial) | | | | | DATE OF BIRTH (Y) | c. RELATIONSHIP TO POLICY HOLDER | | | | | | |
| d. POLICY HOLDER'S EMPLOYE | R'S NAME, AD | DRESS AN | ND TELEPHON | ENU | JMBER | | | | | | | |
| e. INSURANCE COMPANY NAME | . ADDRESS A | ND TELEP | PHONE NUMBE | R | ·· | | | | | | | |
| | • | | , | ., . | | | | • | | | | |
| f. CARD HOLDER ID | g. POLICY I | g. POLICY ID | | | ROUP POLICY ID | I. GROUP PLAN NAME | | | | | | |
| J. ENROLLMENT/PLAN CODE | k. INSURANCE TYPE | | | I. POLICY EFFECTIVE DATE (YYYY/MM/DD) | | | m. POLICY END DATE (YYYY/MM/DD) | | | | | |
| n. (1) PHARMACY (Rx) INSURAN | CE COMPANY | Y NAME, AD | DDRESS AND | TELE | PHONE NUMBER. | | | | | | | |
| | | : | ŕ | | | | | | | * | | |
| (2) Rx POLICY ID | | (3) Rx BI | N NUMBER | | | (4) Rx PCN NUMBER | | | | | | |
| 10. ARE THERE OTHER FAMILY | MEMBERS C | OVERED U | INDER THIS PO | OLIC | Y HOLDER? | | | | | | | |
| a. YES (Proceed to 10c f.) | | | | | b. NO (Proceed to | Item 12.) | | | | | | |
| c. NAME (Last, First, Middle Initial) | d. SSN | e. DATE OF BIRTH YYYY/MM/DD) | f. RELATIONSHIP TO POLICY HOLDER | c. 1 | NAME (Last, First, Middle In | ital) d. | SSN | DATE OF BIRTH | | RELATIONSHIP TO POLICY HOLDER | | |
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| | | | | | | | | | + | | | |
| 11. MEDICARE OR MEDICAID IN a. MEDICARE PART A NUMBER | | | B NUMBER | c. N | MEDICARE MANAGI | ED CARE PI | LAN NAME | | | | | |
| d. MEDICARE PART D NUMBER AND PLAN NAME | | | | e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE | | | | | | | | |
| 12. CERTIFICATION, RELEASE, a. I certify that the information on United States Code, Section 1 b. I acknowledge that the authori United States Code, Sections of this act. c. NON-DoD PATIENTS: I authorized me and/or my minor third-party insurer. d. NON-DoD MEDICARE PATIE limited to patient copayments: e. DoD BENEFICIARIES: I here Service for services provided if ALL PATIENTS: I authorize por released to my insurance carri | this form is true 001, which protect to bill third p 1095 and 1079 prize and reque dependents. A NTS: Lacknow and deductible by acknowledge me and/or my fortions of my m lers. | ue and accupyides for a party payers 9b, and that the est that the ACKNOWLE wedge I am as. ge that the premited frecondical recondical recondic | maximum fine or has been convition personal er proceeds of any EDGEMENT; It responsible for proceeds of any ber. In the proceeds of any ber. In the proceeds of any ber. | of \$2 reyect ntitler y and here r full | 50,000 or imprisonm I to the medical facilit ment to reimburseme I all benefits be paid by agree to pay for a payment of any servi all benefits shall be | ent for five y y within the nt or payme directly to th ny service n ces not cove paid directly | vears, or both. Department on thas been ge MTF for her ot covered in Bred by Medic to the facility | of Defended I granted I althoare whole of care, income | se by o me serv r in p ludin | y Title 10, by virtue ices part by my g but not | | |
| 13a, PATIENT OR ADULT FAMILY MEMBER SIGNATURE | | | | | | | b. DATE (YYYY/MMDD) | | | | | |
| 14a. IF PATIENT REFUSES TO S | IGN THIS FOR | RM: MTFR | EPRESENTAT | IVE | SIGNATURE | | b. DATE (Y | YYY/MM, | (סס | | | |
| ANNUAL PATIENT INSURAN If any information on this form and date at least annually. I certify that the information on of my knowledge. | has changed, | a new form | | | | | | - | | | | |
| 16a, SIGNATURE (Patient or Adult F | 16a, SIGNATURE (Patient or Adult Family Member) | | | | | | | b. DATE (YYYY/MM/DD) | | | | |
| 17. VERIFICATION (2) I a. (1) DATE (YYYY/MM/DD) | NITIALS | b.(1) DAT | TE (YYYY/MM/DE | D) | (2) INITIALS | c.(1) DATE | : (YYYY/MM/DI | D) (2 | 2) INI | TIALS | | |